

Membership Application



Date of Application: ____ / ____ / ____

- New member
- Renewal

Member Name _____

Home Address _____

City _____ State _____ Zip _____ +4 _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Employer _____

Is your employer a Matching Funds Company? _____

Person with Developmental Disability

Name _____ Male / Female *(Circle One)*

Birthdate _____ Type of Disability _____

Is this person receiving a Medicaid Waiver service? Yes/No *(Circle One)* If so, what?

Is this person currently on the waiting list for a waiver? Yes / No *(Circle One)*

Membership Dues

- \$25.00 Family
- \$25.00 Volunteer/Advocate
- \$40 Mental Health Professional / Education Professional
- \$100 Elected Official
- \$150 Small Business/Church/Civic Group
- \$250 Corporate Sponsorship/Board Member
- \$ _____ Additional donation to Special Needs Cobb

(In Honor or Memory of: _____)

Payment Options

- Mail a check payable to Special Needs Cobb to:*
500 Kennesaw Avenue, Suite 900, Marietta, GA 30060